Jefferson School of Population Health

# NJHCQI

# Medicaid ACO Conference

## "Can We Make ACOs Truly Accountable?"

***May 9, 2014***


**David B. Nash, MD, MBA**
**Dean**
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"All the News That's Fit to Print"

The New York Times

VOL. CLXIII ... No. 56,386  SUNDAY, JANUARY 19, 2014

# *Patients' Costs Skyrocket; Specialists' Incomes Soar*

## *When a Doctor Becomes an Entrepreneur, Small Procedures Offer Big Returns*

By ELISABETH ROSENTHAL

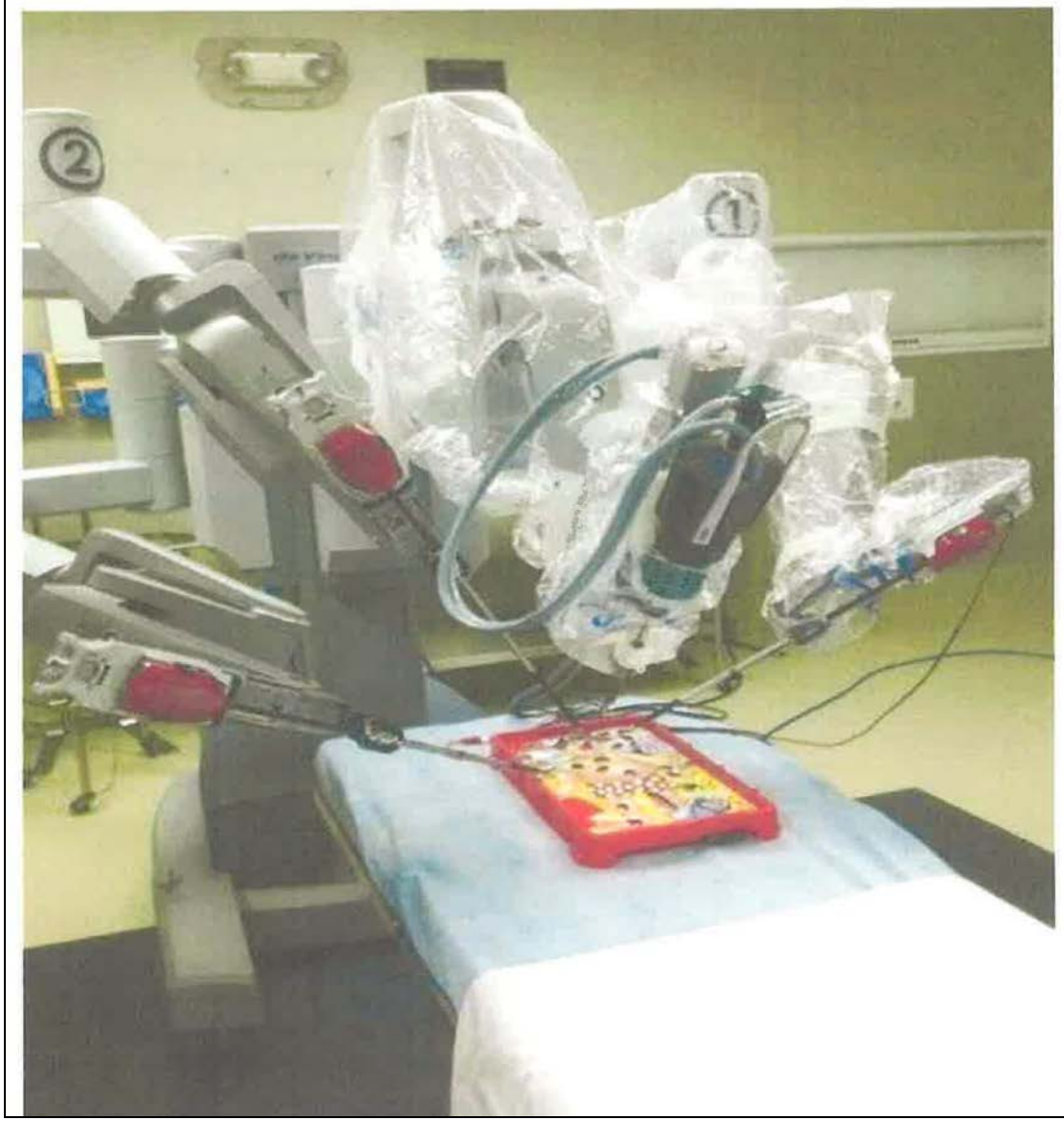
CONWAY, Ark. — Kim Little had not thought much about the tiny white spot on the side of her cheek until a physician's assistant at her dermatologist's office warned that it might be cancerous. He took a biopsy, returning 15 minutes later to confirm the diagnosis and schedule her for an outpatient procedure at the Arkansas Skin Cancer Center in Little Rock, 30 miles away.

That was the prelude to a day-long medical odyssey several weeks later, through different private offices on the manicured campus at the Baptist Health Medical Center that involved a

by becoming more entrepreneurial, protecting their turf through aggressive lobbying by their medical societies, and most of all, increasing revenues by offering new procedures — or doing more of lucrative ones.

It does not matter if the procedure is big or small, learned in a decade of training or a week-long course. In fact, minor procedures typically offer the best return on investment: A cardiac

**PAYING TILL IT HURTS**
*The High Earners*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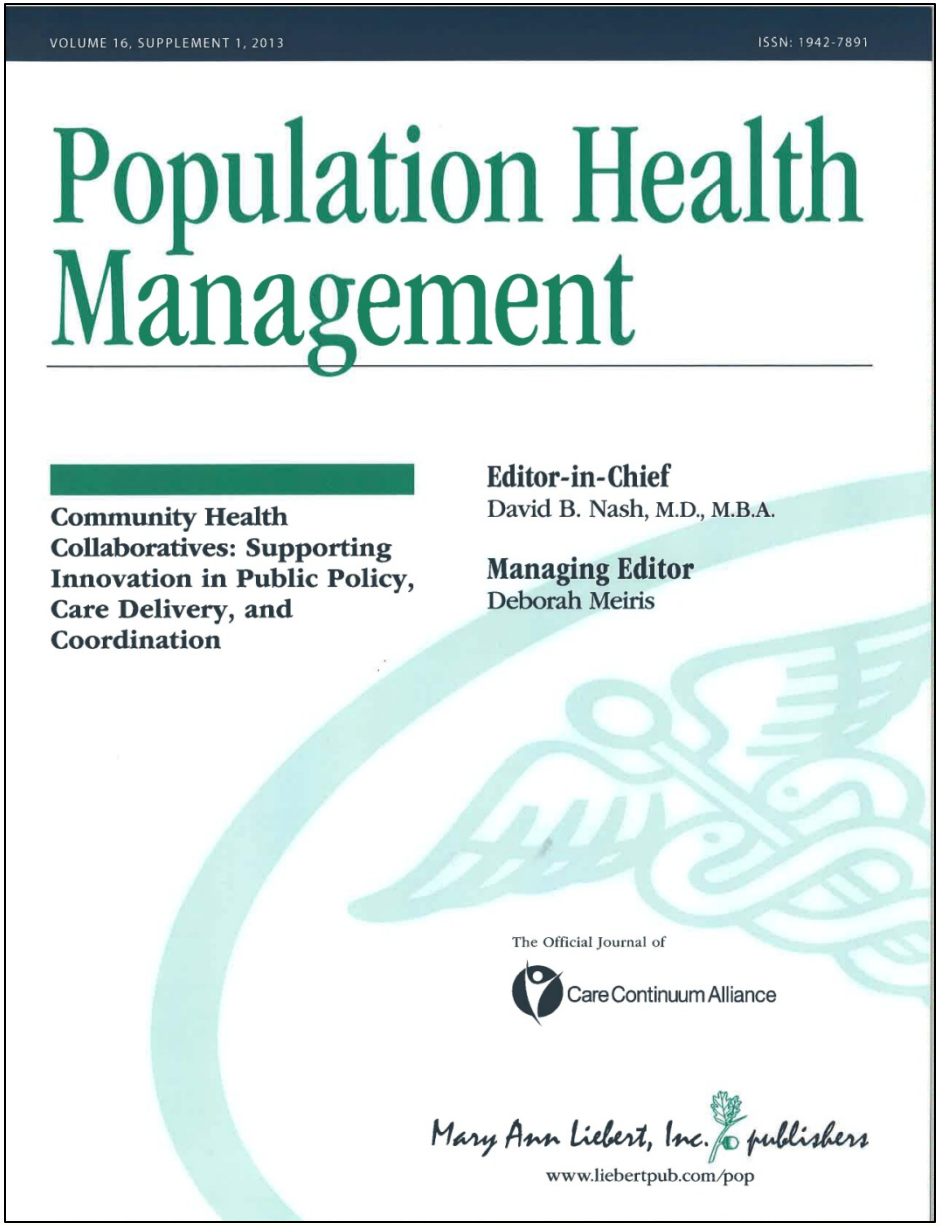


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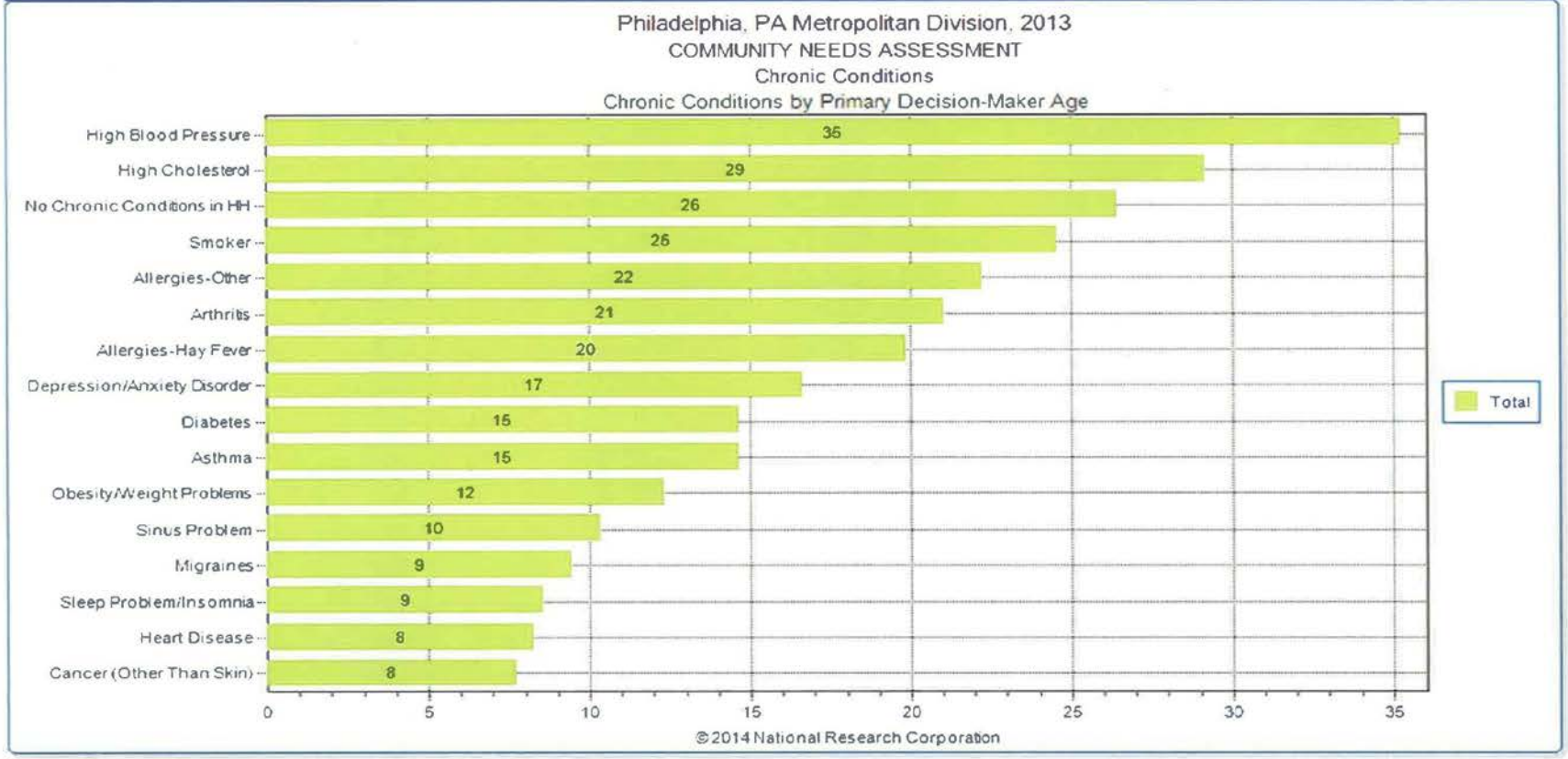
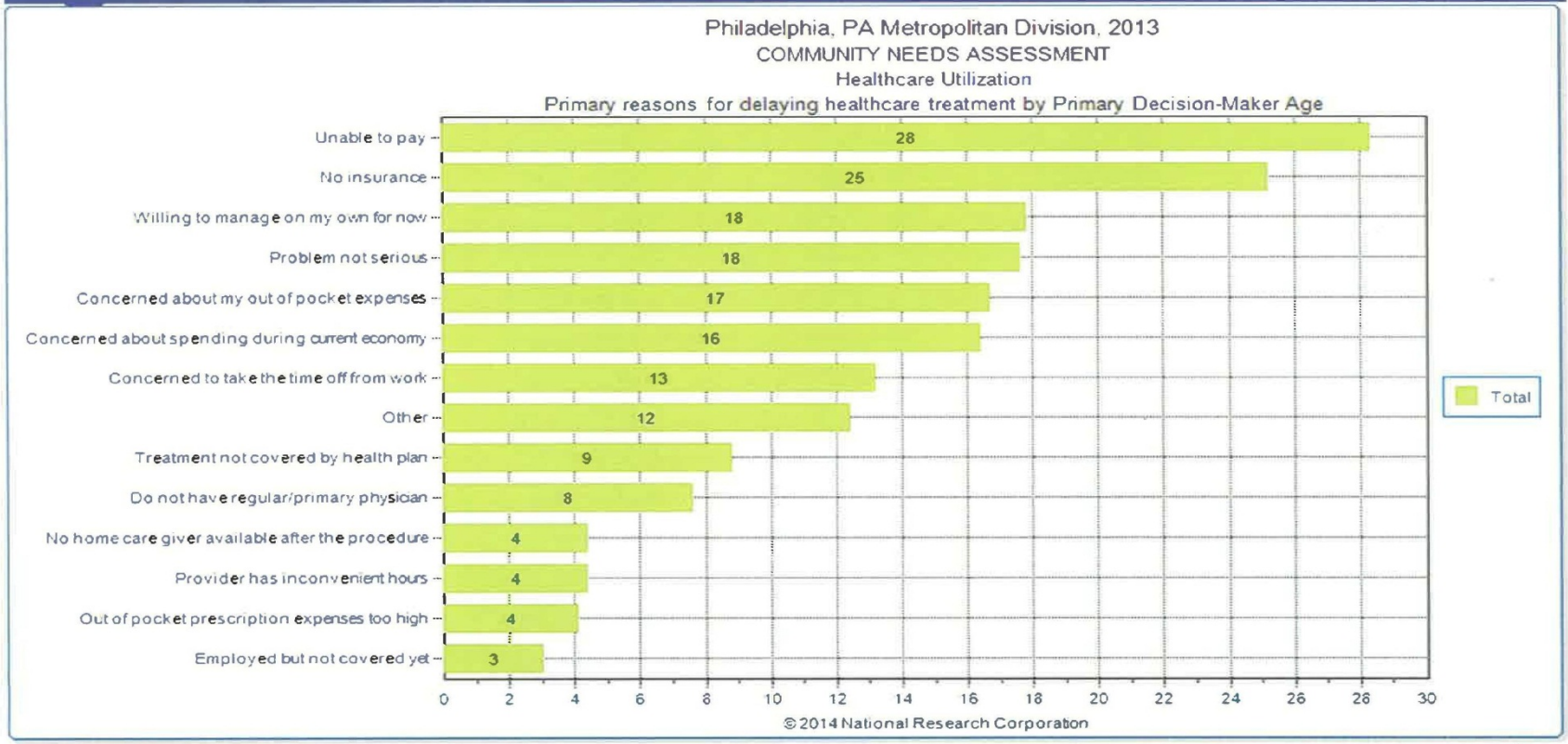
# Top Chronic Conditions




n=3,743 ± 1.6 percent at the 95 percent confidence level

# Reasons for Delaying Healthcare Treatment




n=650 ±3.84 percent at the 95 percent confidence level

By Hilary K. Seligman, Ann F. Bolger, David Guzman, Andrea López, and Kirsten Bibbins-Domingo

DOI: 10.1377/hlthaff.2013.0096
HEALTH AFFAIRS 33,
NO. 1 (2014): 116–123


# Exhaustion Of Food Budgets At Month's End And Hospital Admissions For Hypoglycemia

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**Ann F. Bolger** is a professor in the Department of Medicine, UCSF.

**David Guzman** is a senior statistician in the Department of Medicine, UCSF.

**Andrea López** is a research analyst in the Department of Medicine, UCSF.

**Kirsten Bibbins-Domingo** is a professor in the Department of Medicine, UCSF.

ABSTRACT **One in seven US households cannot reliably afford food. Food budgets are more frequently exhausted at the end of a month than at other points in time. We postulated that this monthly pattern influenced health outcomes, such as risk for hypoglycemia among people with diabetes. Using administrative data on inpatient admissions in California for 2000–08, we found that admissions for hypoglycemia were more common in the low-income than the high-income population (270 versus 200 admissions per 100,000). Risk for hypoglycemia admission increased 27 percent in the last week of the month compared to the first week in the low-income population, but we observed no similar temporal variation in the high-income population. These findings suggest that exhaustion of food budgets might be an important driver of health inequities. Policy solutions to improve stable access to nutrition in low-income populations and raise awareness of the health risks of food insecurity might be warranted.**

In many households, particularly low-income ones, a "pay cycle" develops in which expenditures increase when money (from paychecks or benefits) becomes available, and they decrease just before the next check is due—the time when household budgets are most likely to be exhausted.[1–3] This pattern has been observed for generations. The US Department of Labor noted in 1930 that most factory wage earners spent 75–100 percent of their earnings "by the end of the day following pay day."[4]

More recently, it has been estimated that expenditures by Social Security beneficiaries increase by almost $50 on the day their check arrives—an 80 percent increase over average daily expenditures.[1] A 2009 Gallup poll showed that average daily spending among Americans paid monthly or semimonthly was $62 during weeks without a paycheck and $69 during weeks with a paycheck.[5]

A large proportion of Americans receive their paychecks or government benefits at the start of the month, although the precise percentage is difficult to determine. Some employers prefer to issue paychecks just once a month, to keep money earning interest for the employer for a longer time and reduce costs associated with administering paychecks. Employees who receive monthly paychecks are generally paid on the first days of the month.

Social Security checks arrive on the third day of the month for beneficiaries who retired and began receiving benefits before 1997. Temporary Assistance for Needy Families benefits (often called *welfare benefits*) are often distributed on the first day of the month, depending on the recipient's state of residence. Supplemental Nutrition Assistance Program (SNAP, formerly known as food stamps) benefits in California and many other states are distributed during the first ten days of the month.

Most fixed expenditures are also paid out in the early weeks of the month, leaving less money

REPORT BRIEF JANUARY 2013

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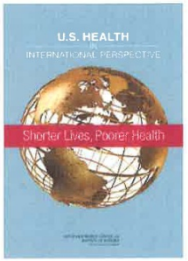
# U.S. Health in International Perspective

## Shorter Lives, Poorer Health




**The United States** is among the wealthiest nations in the world, but it is far from the healthiest. Although Americans' life expectancy and health have improved over the past century, these gains have lagged behind those in other high-income countries. This health disadvantage prevails even though the United States spends far more per person on health care than any other nation. To gain a better understanding of this problem, the National Institutes of Health (NIH) asked the National Research Council and the Institute of Medicine to convene a panel of experts to investigate potential reasons for the U.S. health disadvantage and to assess its larger implications. The panel's findings are detailed in its report, *U.S. Health in International Perspective: Shorter Lives, Poorer Health*.

For many years, Americans have been dying at younger ages than people in almost all other high-income countries. This disadvantage has been getting worse for three decades, especially among women.

### A Pervasive Pattern of Shorter Lives and Poorer Health

The report examines the nature and strength of the research evidence on life expectancy and health in the United States, comparing U.S. data with statistics from 16 "peer" countries—other high-income democracies in western Europe, as well as Canada, Australia, and Japan. (See Table.) The panel relied on the most current data, and it also examined historical trend data beginning in the 1970s; most statistics in the report are from the late 1990s through 2008.

The panel was struck by the gravity of its findings. For many years, Americans have been dying at younger ages than people in almost all other high-income countries. This disadvantage has been getting worse for three decades, especially among women. Not only are their lives shorter, but Americans also have a longstanding pattern of poorer health that is strikingly consistent and pervasive over the life course—at birth, during childhood and adolescence,

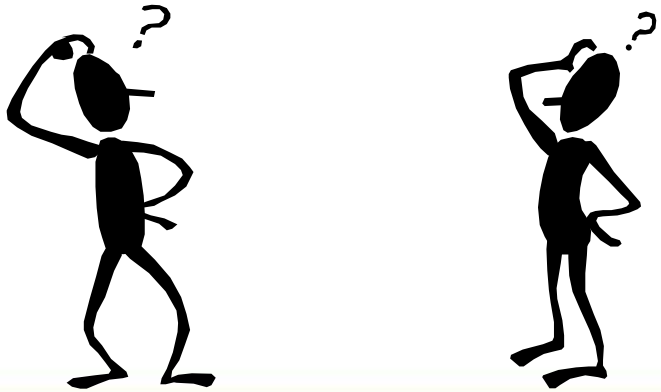

Historical and Current Fee-For-Service
Value-Based Payment and Population Health Management

# Is Population Health the Answer?

1. What's the question?

2. Where are we now?

3. Where are we going in the future?



# Population Health: Conceptual Framework

**Health outcomes**
and their distribution
within a population

***Morbidity***

***Mortality***

***Quality of Life***

**Health determinants**
that influence distribution

***Medical care***

***Socioeconomic status***

***Genetics***

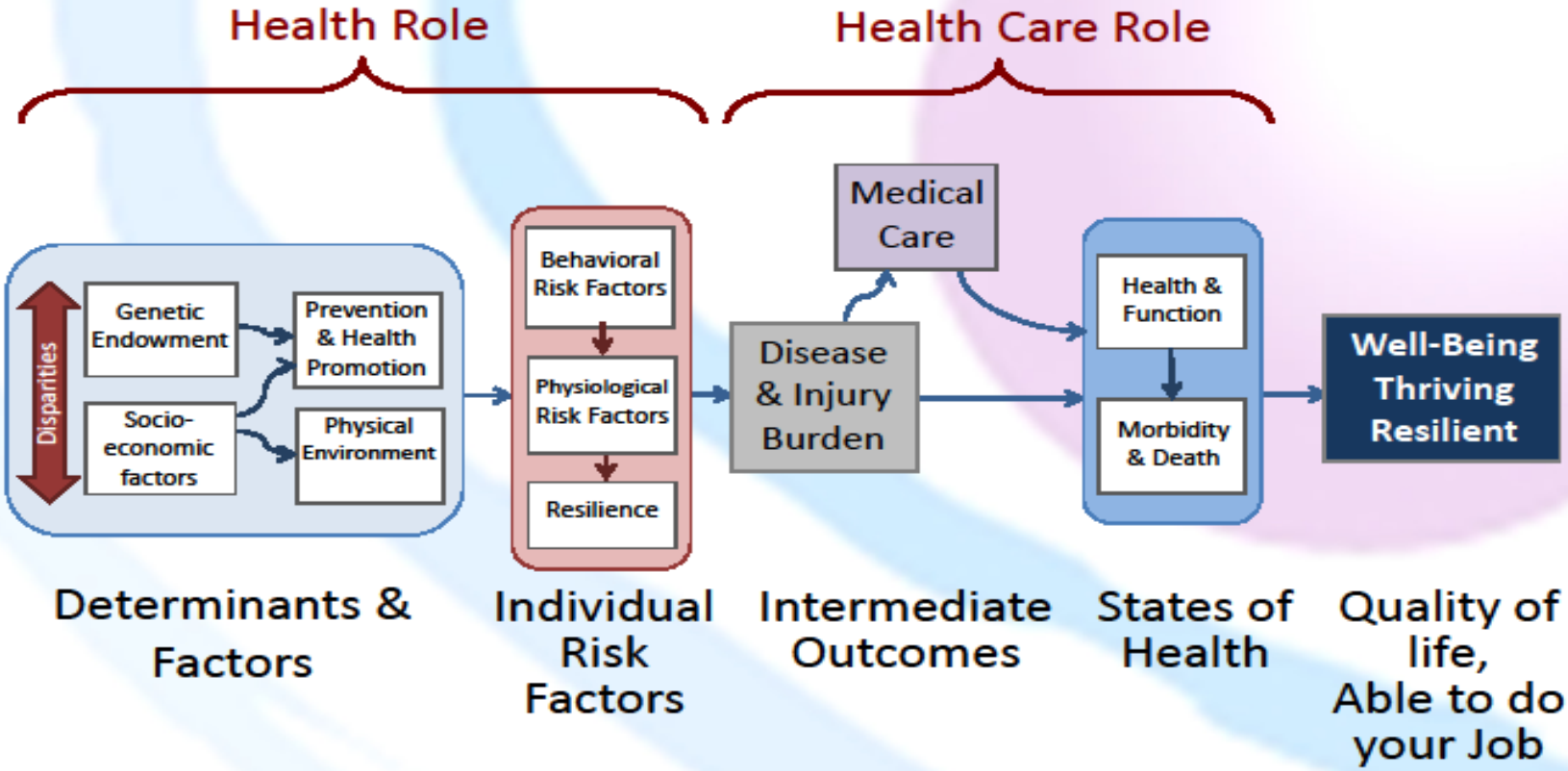
**Policies and interventions**
that impact these determinants

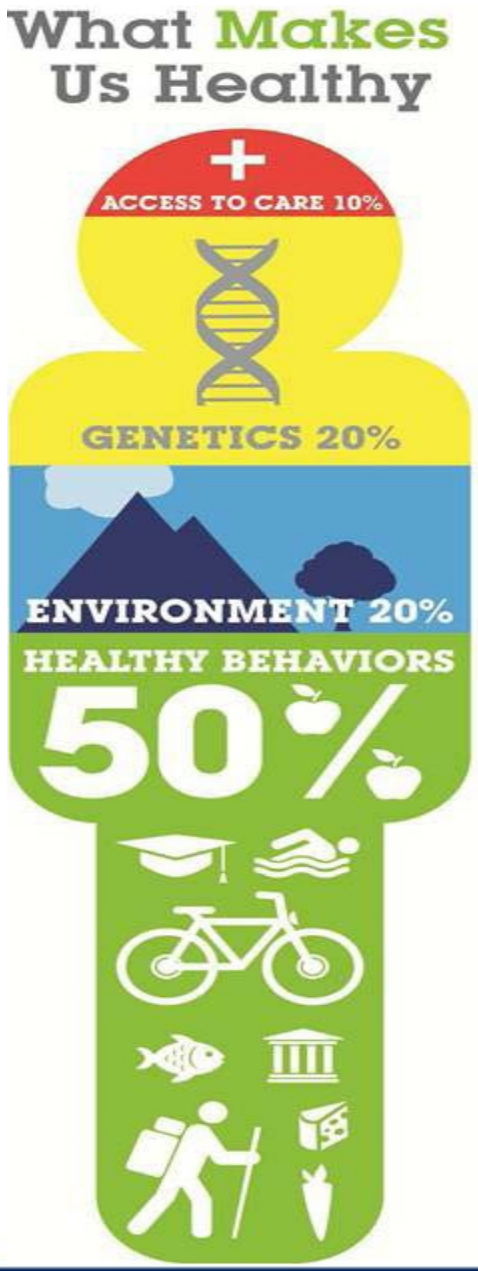
***Social***

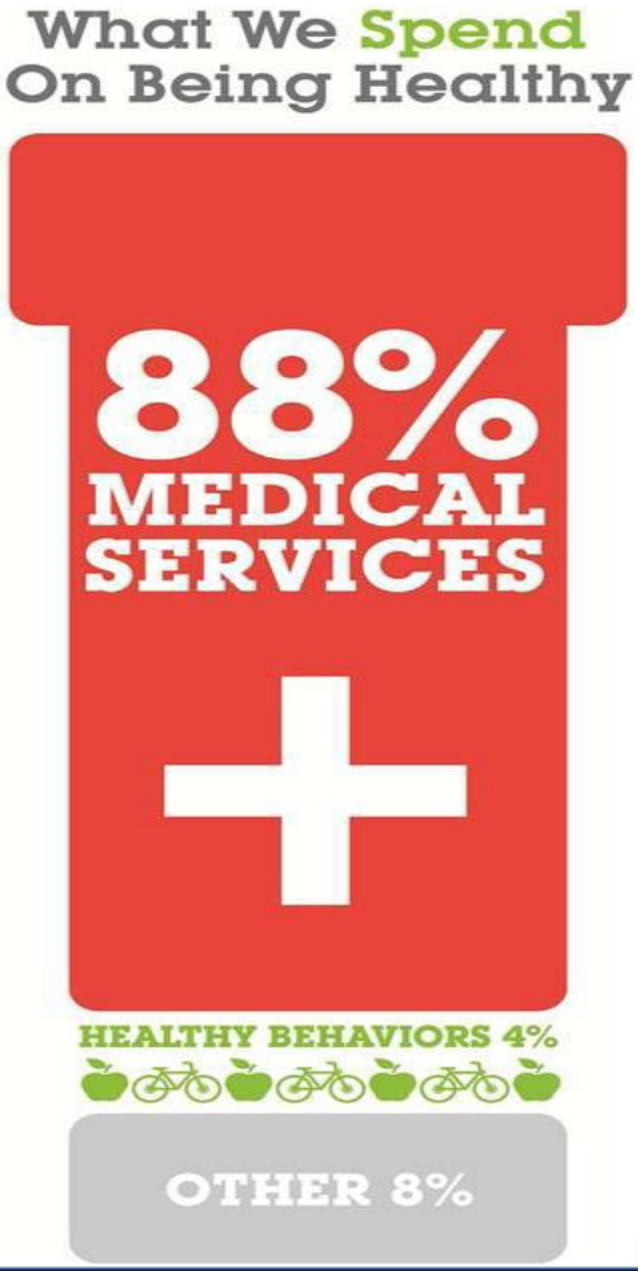
***Environmental***

***Individual***

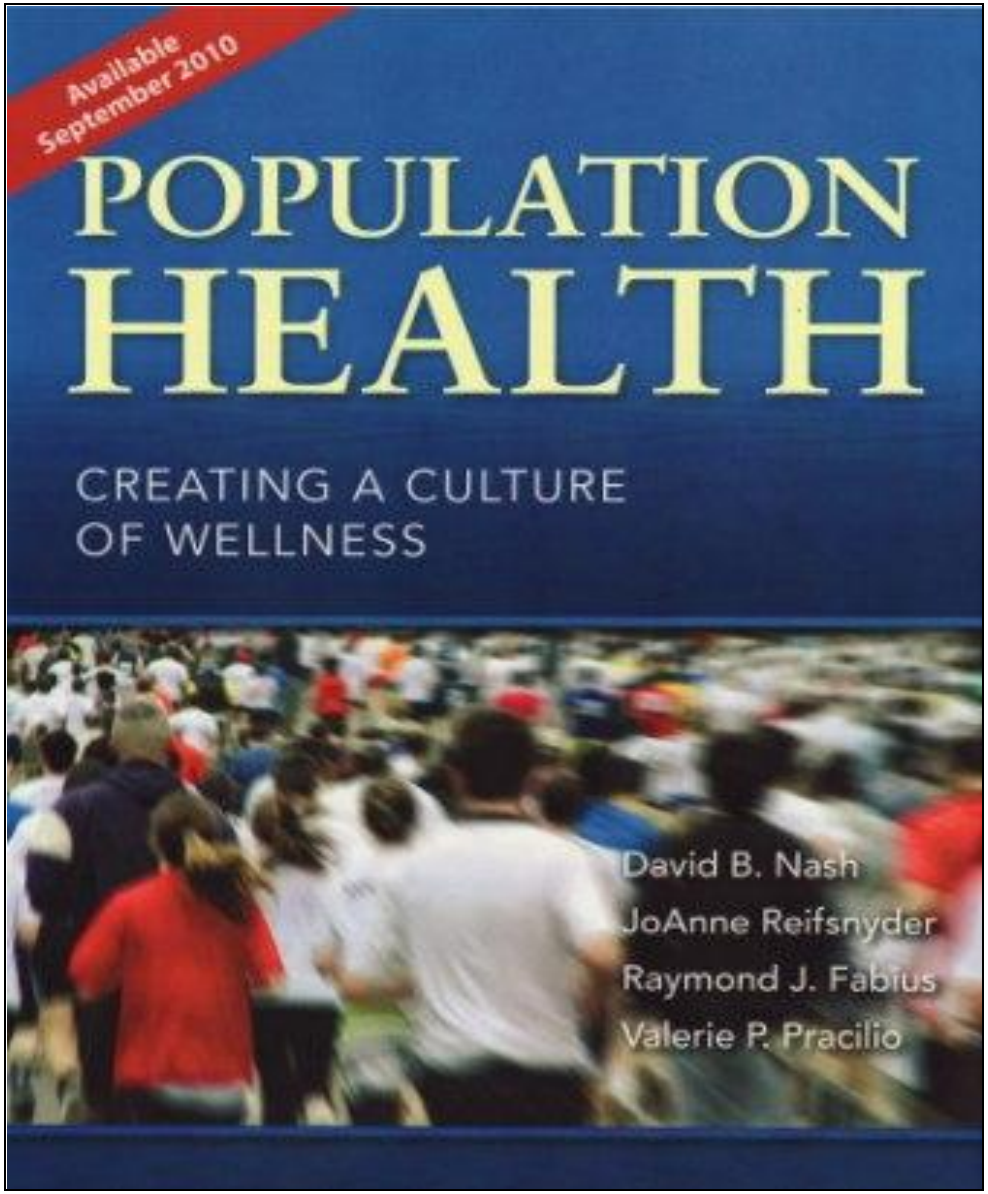
# Broad View of Population Health






Source: Bipartisan Policy Center, "F" as in Fat: How Obesity Threatens America's Future (TFAH/RWJF, Aug. 2013)


Available September 2010
POPULATION HEALTH
CREATING A CULTURE OF WELLNESS
David B. Nash
JoAnne Reifsnyder
Raymond J. Fabius
Valerie P. Pracilio

VOLUME 14, NUMBER 2, APRIL 2011 ISSN: 1942-7891

# Population Health Management

## CONTENTS





The Official Journal of
CareContinuum ALLIANCE

Mary Ann Liebert, Inc. publishers

ISSUE REPORT

# A Healthier America 2013:

## STRATEGIES TO MOVE FROM SICK CARE TO HEALTH CARE IN THE NEXT FOUR YEARS

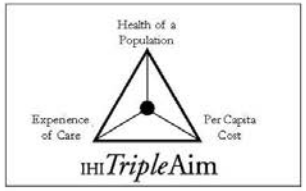
Trust for America's Health
WWW.HEALTHYAMERICANS.ORG

JANUARY 2013

PREVENTING EPIDEMICS.
PROTECTING PEOPLE.

Jefferson School of Population Health

Institute *for* Healthcare Improvement




**Innovation Series 2012**

# A Guide to Measuring the Triple Aim:

## Population Health, Experience of Care, and Per Capita Cost



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# Better Health

…He’s back!

# What Percentage of adult Americans do the following?

1. Exercise 20 minutes 3 x week
2. Don’t smoke
3. Eat fruits and vegetables regularly
4. Wear seatbelts regularly
5. Are at appropriate BMI

Annals Int Med
April 2006

# Determinants of Health

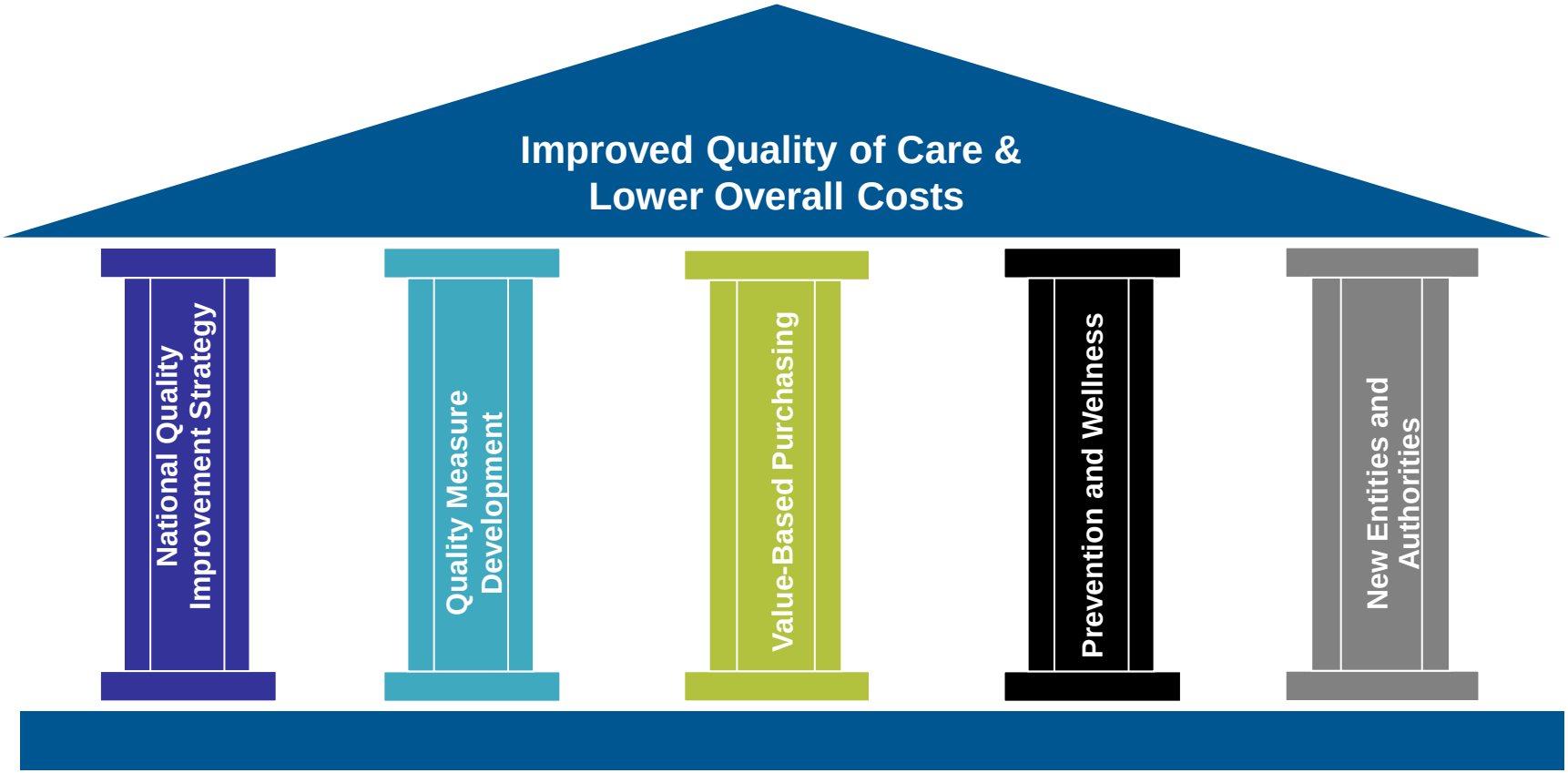
1. Smoking
2. Unhealthy diet
3. Physical inactivity
4. Alcohol use

**Together, these account for 40% of all deaths**

# Reforming Health Care or Reforming Health?

1. US spends under 2% of its health dollars on population health
2. Chronic Diseases, which comprise 80% of total disease burden, have no dedicated federal funding stream

# Health Reform Builds on the Current Quality Infrastructure



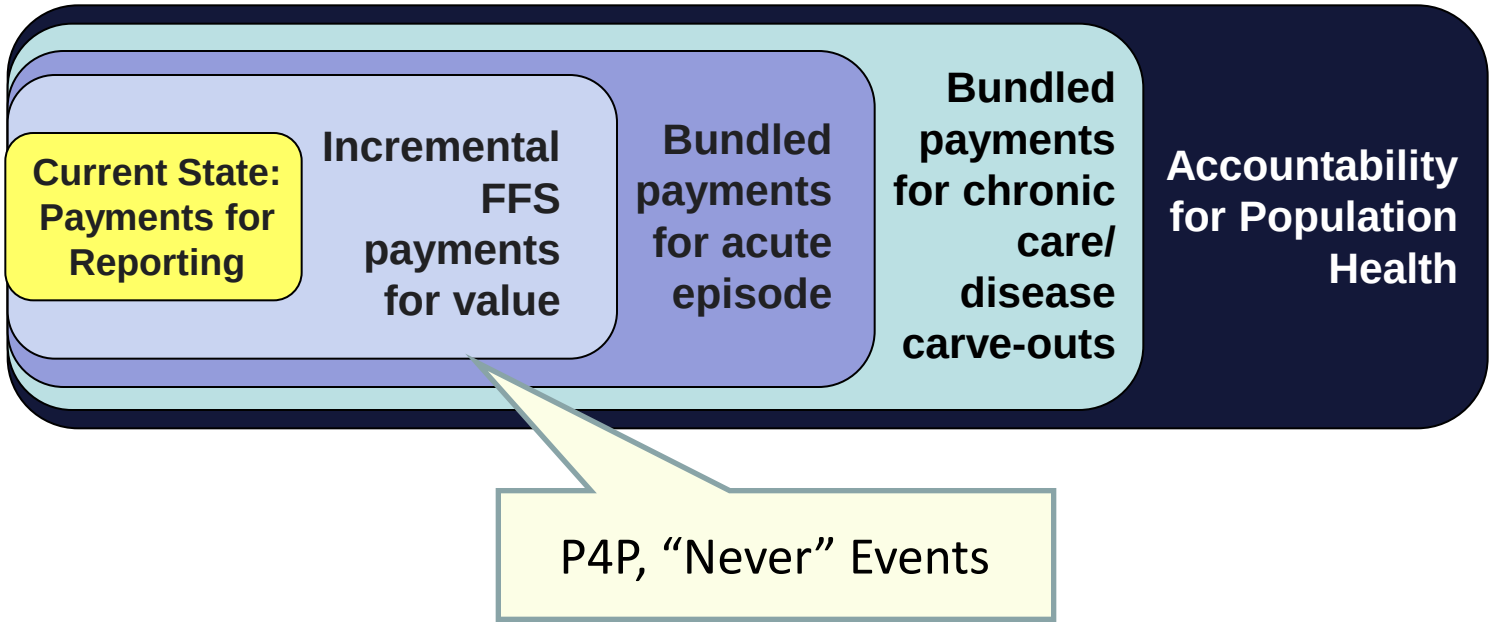
# The Four Underlying Concepts of Cost Containment Through Payment Reform…

| | |
|---|---|
| Tying payment to **evidence and outcomes** rather than per unit of service | **"Bundling" payments** for physician and hospital services by episode or condition |
| Reimbursement for the **coordination of care** in a medical home | **Accountability for results** - patient management across care settings |

# Range of Models in Existence or Development

Increasing assumed risk by provider

Increasing coordination/integration required



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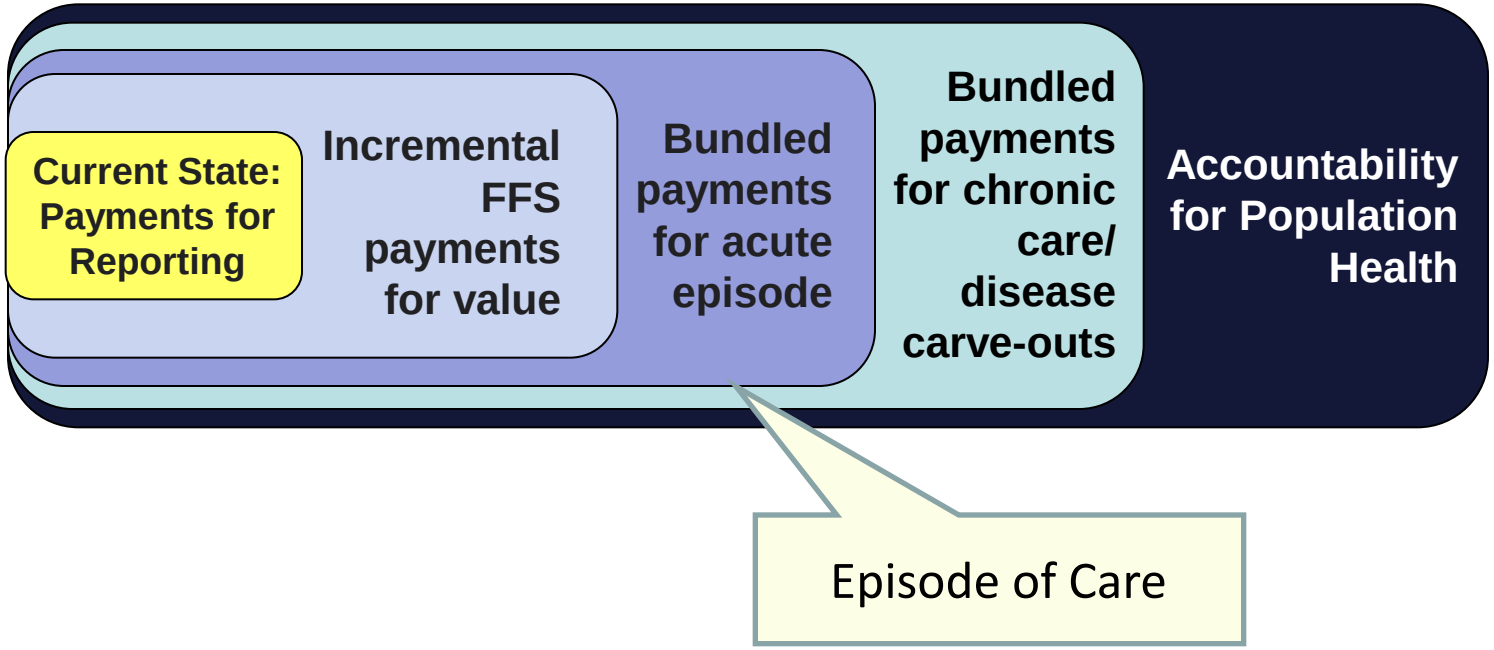
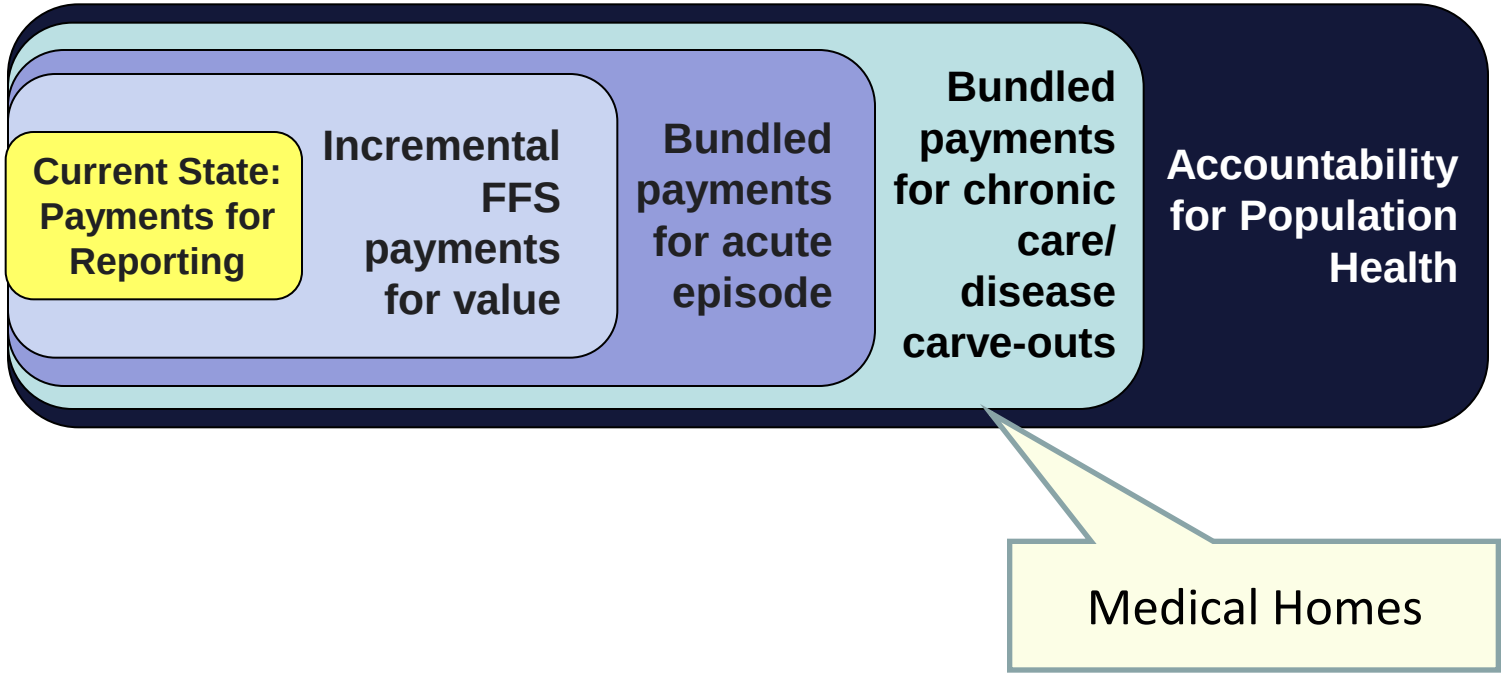


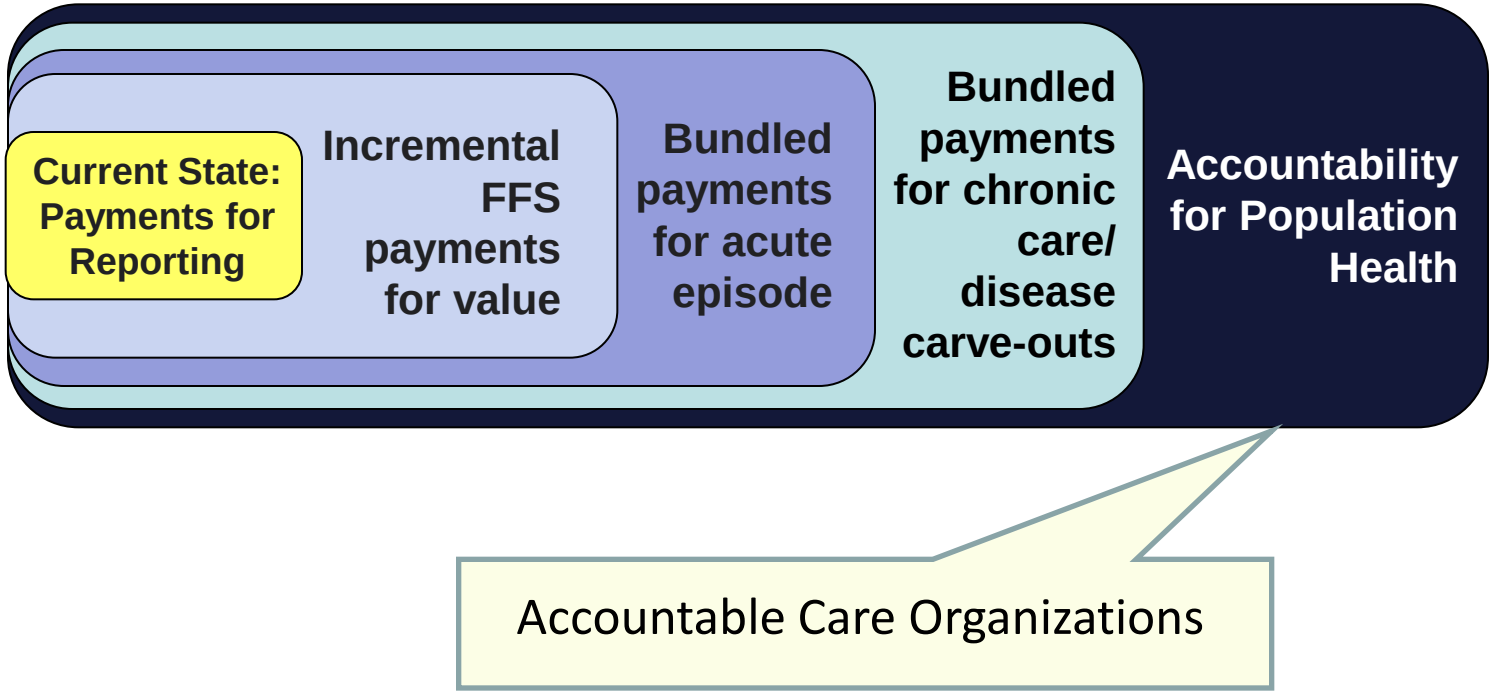
# Range of Models in Existence or Development

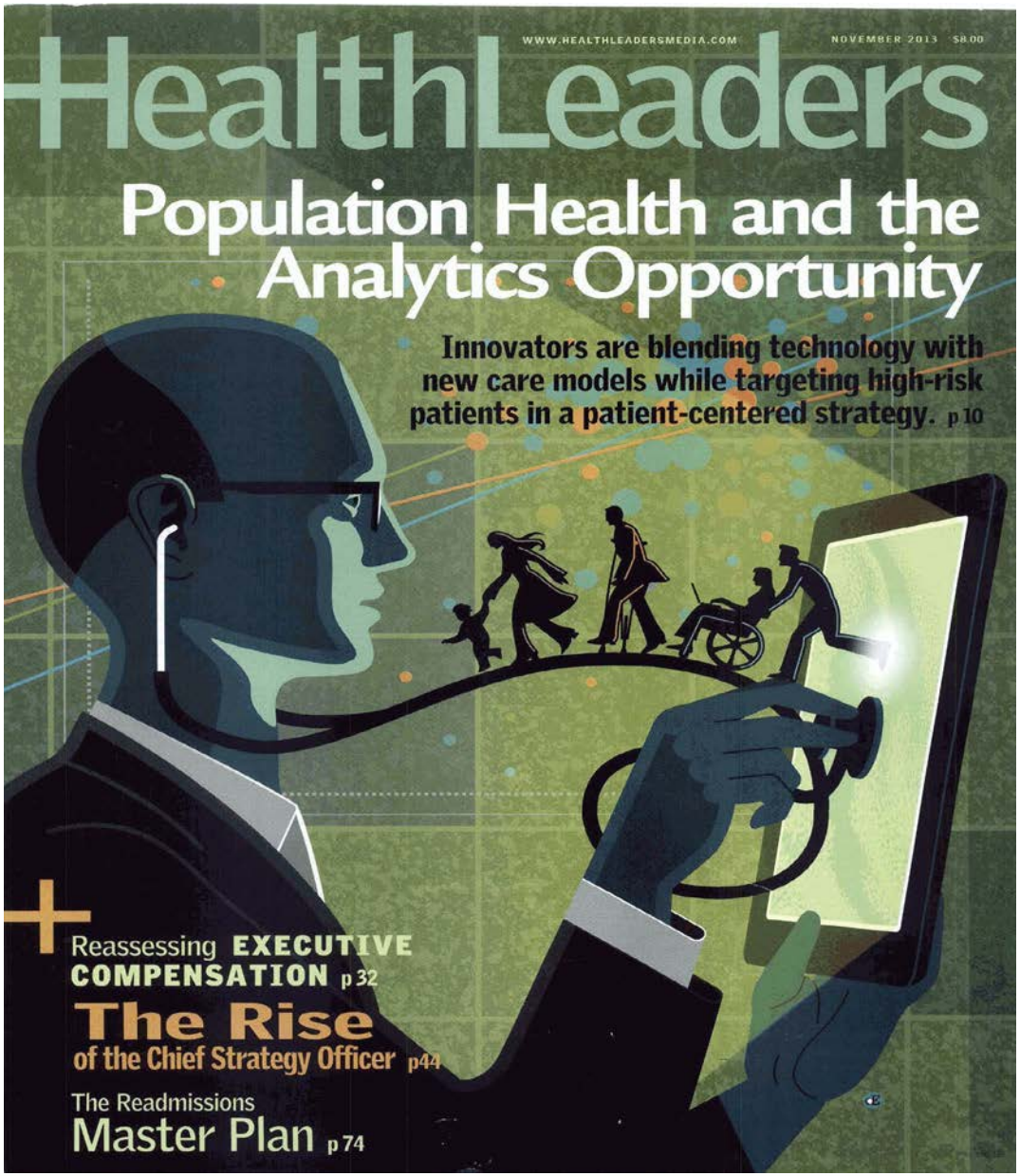


# The Medical Home is Something Fundamentally Different

| • **Usual Care** | | • **Medical Home** |
|---|---|---|
| Relies on the clinician | → | Relies on the team |
| Care provided to those who come in | → | Care provided for all |
| Performance is assumed | → | Performance is measured |
| Innovation is infrequent | → | Innovation occurs regularly |
| Includes only primary care | → | Includes mental health, PharmD's, etc |
| Navigation and care | → | Navigation and care |
| Management not available | → | Management are required |
| H.I.T. may or may not support care | → | H.I.T. must support care |

# Range of Models in Existence or Development




WWW.HEALTHLEADERSMEDIA.COM
NOVEMBER 2013 $8.00
HealthLeaders
Population Health and the Analytics Opportunity
Innovators are blending technology with new care models while targeting high-risk patients in a patient-centered strategy. p 10
+
Reassessing EXECUTIVE COMPENSATION p 32
The Rise of the Chief Strategy Officer p44
The Readmissions Master Plan p 74

PHYTEL

Help · Kevin Johnson

# Population Management System

Search Patients | Go

Patients | Appointments | Outreach | Population Insight | Care Management | PQRS | Hospital Readmission | Reports

Condition Dashboard | Population Benchmarks | Comparison | Population Summary | Data Summary | Patient List | Configuration

Date Range:
Monthly
**Quarterly**

Recent Reports:
**Annual HbA1C**
Annual LDL-C testing
Physician Comparison

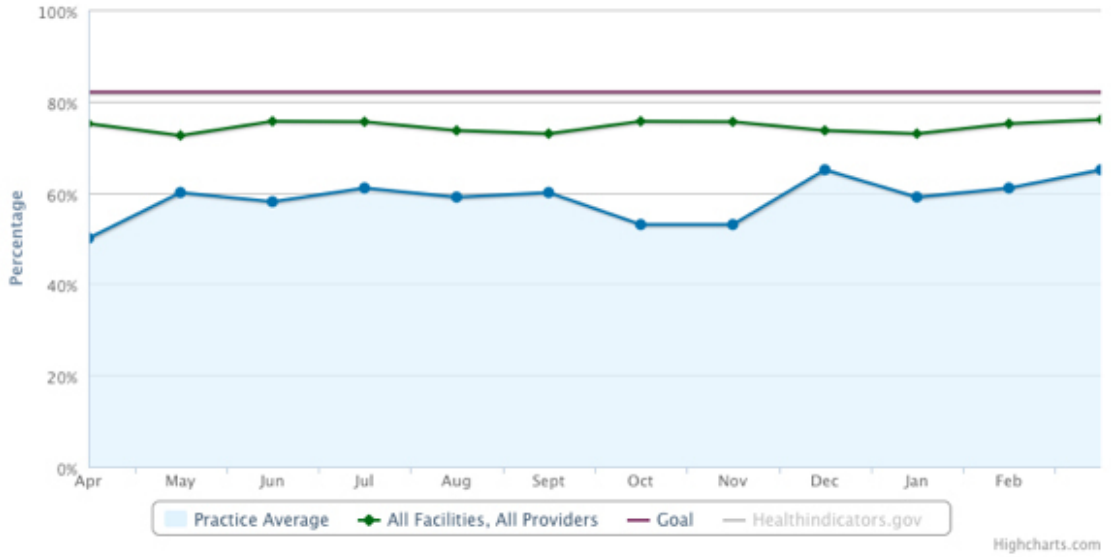
Group: Medical Center, Westside | Provider: 17 Providers

## Population Benchmark Report

Export

Report: Quality Initiative | Diabetes | Operational | Annual HbA1C testing

### Annual HbA1C testing




| Diabetes | Benchmark | QTR 1 (2011) | | QTR 4 (2010) | | QTR 3 (2010) | | QTR 2 (2010) | | QTR 1 (2010) | | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Identified Population | | 2,183 | | 2,167 | | 2,180 | | 2,166 | | 2,168 | | |
| **Measures** | % | # | % | # | % | # | % | # | % | # | % | |
| Annual HbA1c testing | 85.3 | **1,773** | **80.1** | 1,754 | 81 | 1,761 | 81.6 | 1,752 | 81 | 1,764 | 81.6 | ↑ |
| HbA1c > 9.0 | 12.2 | **220** | **13.0** | 208 | 12.7 | 208 | 13.7 | 232 | 12.2 | 213 | 18.0 | ↔ |
| HbA1c < 7.0 | 45.3 | **862** | **40.8** | 832 | 42.5 | 928 | 42.4 | 926 | 41.9 | 910 | 41.5 | ↓ |

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SYNAPSE

Search... Search

Dan Bergner | Help & Training | Risk Stratification

Home | Chatter | Dashboards | Contacts | Diagnosis-Related Groups | ICD-10 Codes | Claims | Reports | Integration | +

« Go to Dashboard List

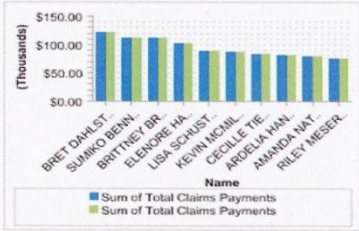
# CHF & COPD Population Dashboard

Help for this Page

Find a dashboard... | Edit | Clone | Refresh | As of August 6, 2013 at 4:13 PM | Viewing as Dan Bergner

## CHF & COPD Population by Status


## CHF Population




## COPD Population


## 10 Most Costly Claim Codes

| DRG | Sum of Claim Payment Amount |
|---|---|
| AFTERCARE W/O CC/MCC | $1.5M |
| O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W/O CC/MCC | $1.5M |
| SIGNS & SYMPTOMS W MCC | $1.5M |
| REHABILITATION W/O CC/MCC | $1.3M |
| AFTERCARE W CC/MCC | $1.3M |
| SIGNS & SYMPTOMS W/O MCC | $1.2M |
| PULMONARY EMBOLISM W/O MCC | $1.2M |
| OTHER FACTORS INFLUENCING HEALTH STATUS | $1.1M |
| RESPIRATORY NEOPLASMS W CC | $1.1M |
| MAJOR CHEST TRAUMA W MCC | $1.1M |
| Total | $12.8M |

## Physicians with Most Costly Claims

| Attending Physician | Sum of Claim Payment Amount |
|---|---|
| FRANK MCGEEHAN | $1.9M |
| ALFRED NUTT | $1.5M |
| ELIZA MARR | $1.5M |
| LUCILA BURRIS | $1.5M |
| FLO SPINO | $1.1M |
| HIRAM SHACKLEFORD | $1.1M |
| KARINA ACKLEY | $991K |
| ERIC DUNNEBACK | $952K |
| NATALIE RAGIN | $918K |
| AMAL MCMILLON | $861K |
| Total | $12.1M |

## Top 10 Physicians - AFTERCARE W/O CC/MCC

| Attending Physician | Sum of Claim Payment Amount | Sum of No. Claims |
|---|---|---|
| HELENA PALMATIER | $41K | 2 |
| SEAN SWARTZ | $41K | 1 |
| AARON THIESSEN | $39K | 1 |
| LANI TOMBERLIN | $37K | 1 |
| LUCILA MASK | $35K | 3 |
| VESTA YOPP | $35K | 1 |
| ALFRED NUTT | $33K | 3 |
| KRAIG GAFFORD | $33K | 2 |
| SHAWANA BESSETTE | $32K | 1 |
| ZULEMA TANAKA | $28K | 1 |
| Total | $354K | 16 |

# Humana's Accountable Care Organization pilot

- Unites expertise of Humana and Norton Healthcare of Louisville
- One of only five pilots in the U.S. authorized by Dartmouth and Brookings
- Accountability of measured outcomes, cost, and patient delivery
- Industry-standard performance measures including financial, quality, regulatory
- Core principles:
  - Integrated care delivery among provider teams
  - Defined patient population to measure
  - Pay-for-results based on improved outcomes and cost

THE DARTMOUTH INSTITUTE FOR HEALTH POLICY & CLINICAL PRACTICE
Where Knowledge Informs Change

BROOKINGS

NORTON HEALTHCARE

Mission:

**Improve the health of people in our region**

Our vision:

**St. Luke's Health System will transform healthcare by aligning with physicians and other providers to deliver integrated, seamless and patient-centered quality care across all St. Luke's settings.**

Based on our vision we are compelled to deliver on the principles of Accountable Care:

**Better Health, Better Care, Lower Cost**

In order to achieve this, we must manage the health of populations. This means transitioning from volume to value. We will do this by achieving these strategic objectives:

| Transform The Clinical Care Model | Transform The Business Model | Transform The Consumer Experience |
|---|---|---|

Strategic initiatives that support our strategic objectives:

| Align The SLHS System: | Connect Ourselves & Our Communities: | Eliminate Waste: | Create a Clinically Integrated Network: | Become a National Quality Leader: | Expand Patient Centeredness: |
|---|---|---|---|---|---|
| • Establish a clear, inclusive & effective governance structure<br>• Incorporate innovation, creativity & continuous learning into our culture.<br>• Develop leaders throughout the organization, including physicians<br>• Align provider compensation to enable the move from volume to value | • Maximize problem solving as close to the issue as possible<br>• Enhance the way consumers & partners interact with care providers<br>• Broaden St. Luke's brand from caring only for illness & injury to include partnering for health<br>• Partner with local community resources & employ community health needs assessments<br>• Promote philanthropic investment | • Accelerate TEAMwork-based (Lean) reduction of waste, irrational variance & cost in operational & clinical areas<br>• Mobilize utilization management capability<br>• Maximize the use of every organizational asset | • Transition our business (lives & contracts) from fee-for-service to accountable care.<br>• Create a system of clinical accountability across all providers in the network<br>• Engage a sufficient number of committed & aligned independent providers<br>• Evaluate & execute strategic relationships that expand care continuum capability | • Be a national quality & consumer satisfaction leader based on national benchmarks<br>• Drive safety toward zero harm<br>• Develop coordination & transitions of care disciplines, including new care models (e.g., Team Based Care) | • Promote a patient centric approach to care<br>• Engage people in their health<br>• Promote the patient's partnership in managing their care<br>• Incorporate effective & proven approaches to preventative & end of life care |

**Establish Information-Driven Decision-Making:**

Foundational to these initiatives, we must fuel adoption of data and analytics to make evidence-based management and clinical decisions, and objective decisions on how we prioritize our resources & understand risks.

Our workforce embodies the St. Luke's Values of ICARE as we deliver the following pledge:

| Create Exceptional Experiences | Create Exceptional Outcomes |
|---|---|

By Susan DeVore and R. Wesley Champion

# Driving Population Health Through Accountable Care Organizations

DOI: 10.1377/hlthaff.2010.0935
HEALTH AFFAIRS 30,
NO. 1 (2011): 41–50


ABSTRACT Accountable care organizations, scheduled to become part of the Medicare program under the Affordable Care Act, have been promoted as a way to improve health care quality, reduce growth in costs, and increase patients' satisfaction. It is unclear how these organizations will develop. Yet in principle they will have to meet quality metrics, adopt improved care processes, assume risk, and provide incentives for population health and wellness. These capabilities represent a radical departure from today's health delivery system. In May 2010 the Premier healthcare alliance formed the Accountable Care Implementation Collaborative, which consists of health systems that seek to pursue accountability by forming partnerships with private payers to evolve from fee-for-service payment models to new, value-driven models. This article describes how participants in the collaborative are building models and developing best practices that can inform the implementation of accountable care organizations as well as public policies.

**Susan DeVore** (susan_devore@premierinc.com) is president and chief executive officer of the Premier healthcare alliance, in Charlotte, North Carolina.

**R. Wesley Champion** is a senior vice president at Premier Consulting Solutions, in Charlotte.

# Lucky 7

## Population Health TO DO LIST:

1. What about your own associates? (HRAs, Wellness & Prevention)
2. Keep the well, well!
3. PCMH's (who will lead?)
4. Registries (not in current EMRs yet)
5. Retail clinics (Walgreens, CVS)
6. Managed Care Partners
7. Leadership Training

# Strategic Humor

# What Does This All Mean?

Major Themes Moving Forward

1. Transparency
2. Accountability
3. No outcome, No income

# How Might We Get There?

**Change the Culture**

1. Practice based on evidence
2. Reduce unexplained clinical variation
3. Reduce slavish adherence to professional autonomy
4. Continuously measure and close feedback loop
5. Engage with patients across the continuum of care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Politics/
Policy
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46.9% return
22.8% return
13.8% return
S&P 500
Obamacare stock fund
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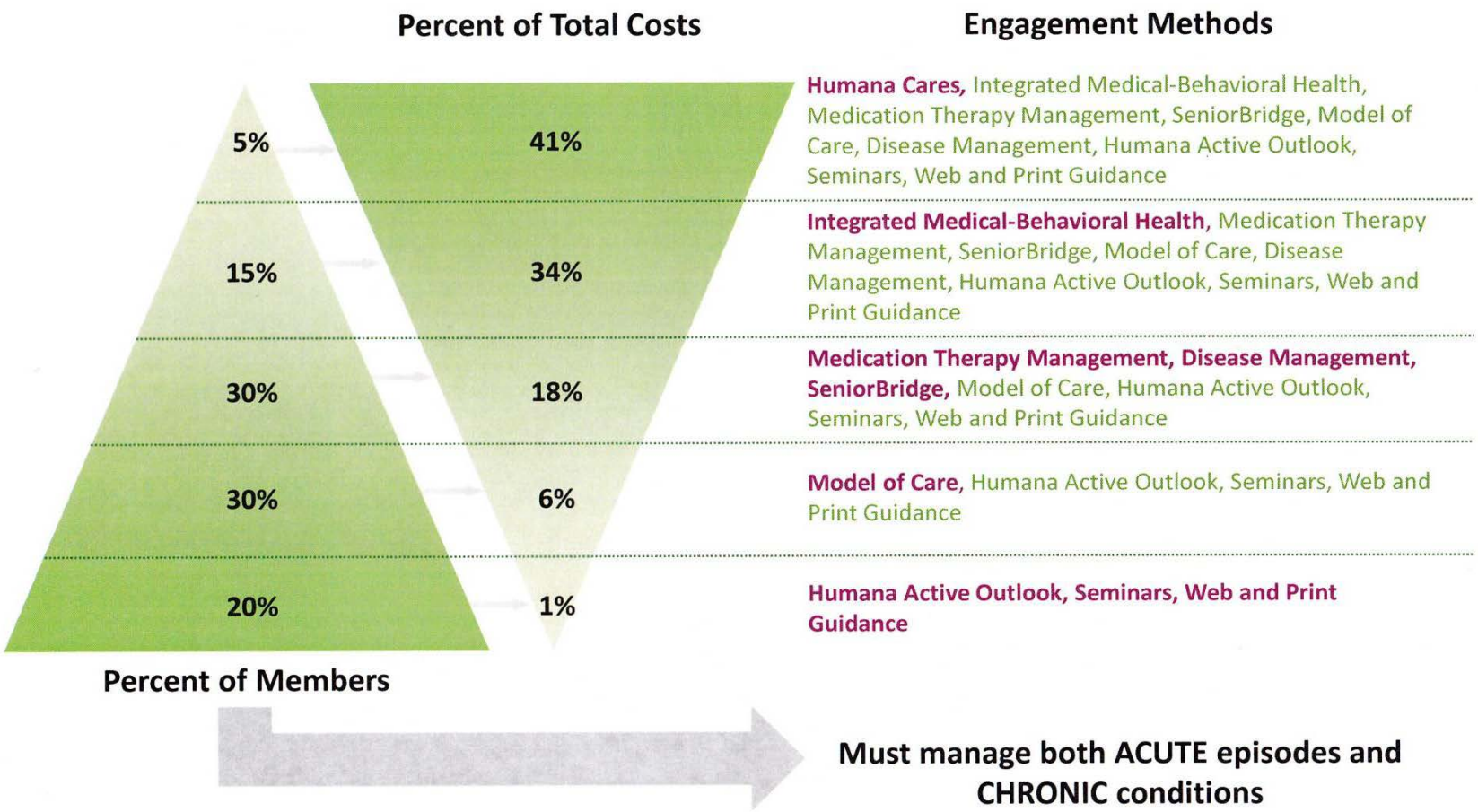
# Retail Senior Segment
# Medical Management of Members Across a Continuum on Needs

*We are focused in managing high cost / high acuity patients both Acute and Chronic*




Humana

Note: Senior Bridge deal is pending

# arket Landscape of Health & Wellnes

4

**The H&W landscape is fragmented, with a major opportunity for a player to assemble "sticky" value-add offerings to create a comprehensive platform**

***Spectrum of Product / Service Offerings***

| *Disease / Pop. Health Mgmt* | *Wellness Services* | *Onsite Clinics/ Programs* | *Information & Engagement* | *Incentives & Program Admin* | *Digital Tools/ Content* |
|---|---|---|---|---|---|
| • Disease Management<br>• Lifestyle Management<br>• Chronic Care Management | • Screenings<br>• Coaching<br>• Assessments<br>• Diet & Nutrition<br>• EAP | • Onsite Clinics<br>• Fitness Programs<br>• Occupational Medicine | • Health Advocacy<br>• Navigation<br>• Transparency<br>• Multi-Channel Outreach | • Plan Design and Forecasting<br>• Incentive Management<br>• Administration and Program Mgmt.<br>• Incentives Fulfillment<br>• Analytics and reporting | • Consumer Wellness Portal<br>• Personalized Content<br>• Gaming and Social Tools<br>• Mobile / Wireless / Virtual Capabilities<br>• Quantified Self |

Kaiser Permanente, Mayo Clinic, Alere, Healthways, Optum — Other Payers: CVS Caremark

Weight Watchers, (Optum), hhs, Impact Health, Life Line Screening, WebMD, Hooper Holmes, Trotter Wellness, Summit Health

healthspot, +1 (United), healthcare clinic (Walgreens), CHS, U.S. HealthWorks

HealthAdvocate, Accolade, Compass Healthcare Advisers, Castlight Health, Change Healthcare, Healthcare Blue Book, ZocDoc

Redbrick Health, NOVU, ChipRewards (Fidelity National), Bravo Wellness, LinkWell (WellPoint), provant

healthoop, Audax health, keas, mindbloom, WellnessFX, Jawbone, BodyMedia

Humana, Concentra LifeSynch, HRI, Hummingbird, Concentra, Humana Vitality, Healthrageous

**How could Humana begin to think about building a health & wellness enterprise of significant relevancy and size?**

JOURNAL REPORT

HEALTH CARE

THE WALL STREET JOURNAL.

Monday, February 24, 2014 | R



Follow The Experts
An Online Conversation
DETAILS, R2

# How to Bring the Price Of Health Care Into the Open

There's a major effort under way to make sure patients know what they'll have to pay—*before* they make any decisions about treatment. Some people think it will make all the difference.

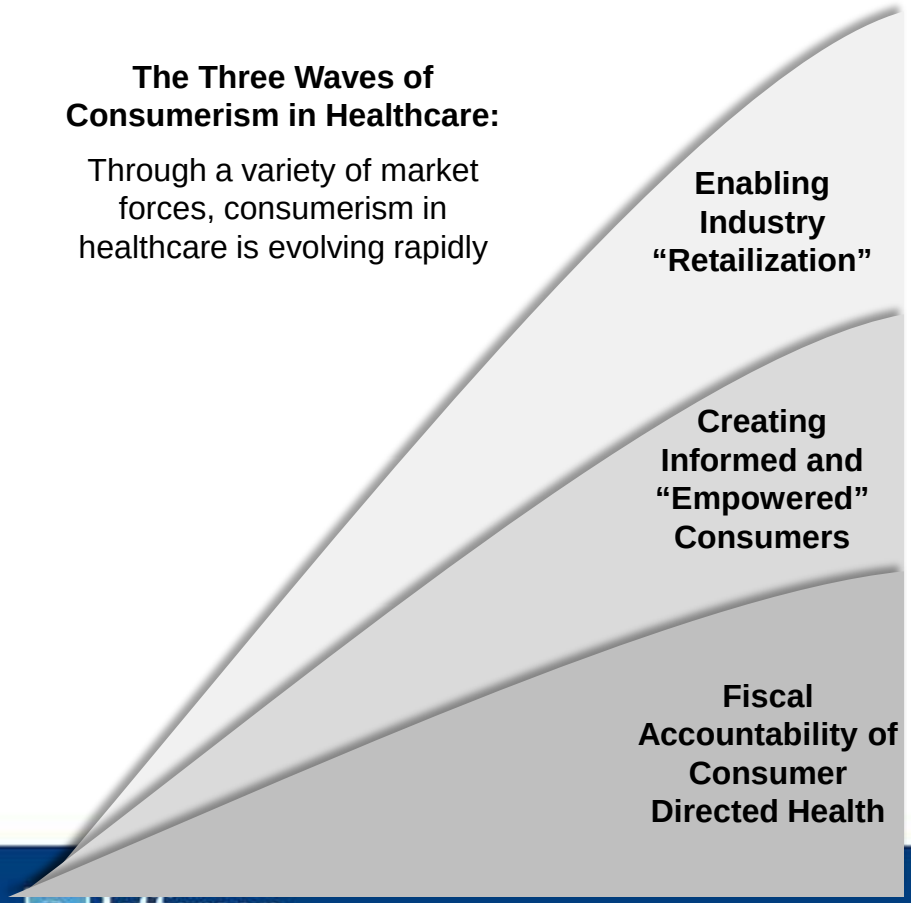
# Consumers Need Decision Making Support

5

**The rise of consumerism creates demand for individual control and decision support that accommodates a B2B2C "retail experience" not previously delivered in US healthcare.**

**The Three Waves of Consumerism in Healthcare:**

Through a variety of market forces, consumerism in healthcare is evolving rapidly



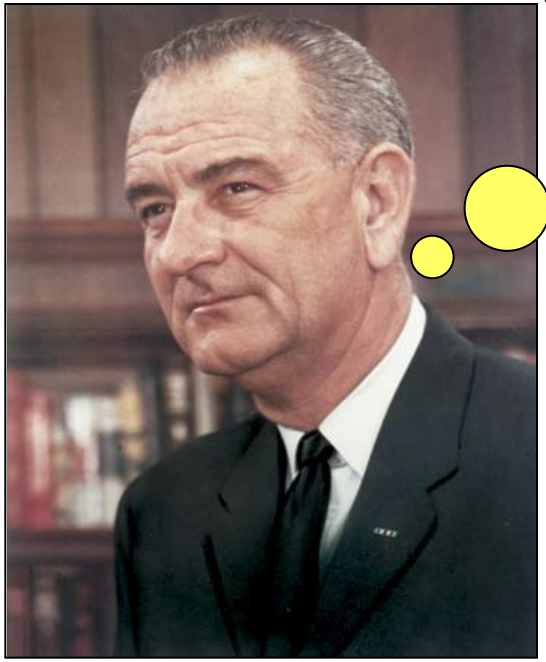

- ✓ Benefit education and navigation assistance
- ✓ Consumer engagement and high-touch decision support
- ✓ Member satisfaction and customer service
- ✓ Active health management
- ✓ Cost and benefit transparency
- ✓ Comparison and selection tools





Jefferson
School of Population Health

**“It’s always better to have them in the tent pissing out, than outside the tent pissing in.”**



*President, L.B. Johnson*